DRAFT

Laguna Honda Hospital Reform Plan

San Francisco Department of Public Health

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INTRODUCTION

On June 28 of this year, Mayor London Breed, President of the Board of Supervisors Norman Yee and Health Director Dr. Grant Colfax reported directly to the community about patient abuse issues involving patients of Laguna Honda Hospital and Rehabilitation Center (LHH). Director Colfax announced that a reform plan for LHH would be submitted to the Mayor, the Board of Supervisors and the Health Commission within 60 days.

The incidents of misconduct reported in June do not represent the values of LHH, the San Francisco Health Network, or the Department of Public Health (DPH), and will not be tolerated. LHH has had a positive effect on generations of San Franciscans and continues to be a good place for patients.

DPH leadership notified patients and their families/caregivers, conducted wellness checks for all patients, provided training on preventing and reporting patient abuse to all staff, made improvements in drug dispensing and monitoring policies, and made substantial changes to hospital leadership. The 6 staff members directly involved are no longer employed by the city.

This document, the Department of Public Health's Reform Plan for LHH, includes the critical components of reestablishing patient safety, operating quality and regaining public trust: **(1)** Ensuring compliance with all State and Federal Regulations; **(2)** Reorganization of hospital leadership and the quality and safety management program; and **(3)** Collaboration with and advisement from experts in long term care to better prepare LHH for the future and guiding it to regain its stature as a world-class institution.

This plan represents a road map for action and, like all plans, may change subject to new information, including the outcome of continuing investigations.

(1) Ensuring compliance with state and federal regulations

All hospitals must operate in conditions which are safe and provide satisfactory levels of care. Consequently, first and foremost, LHH must ensure compliance with all State and Federal regulations to the satisfaction of relevant regulatory agencies; both State and Federal regulatory agencies have approved the Plan of Correction submitted by LHH staff (see Appendix 1: CDPH Findings and Plan of Correction).

Below are key issues identified as primary contributing factors regarding employee misconduct at LHH:

- **CULTURE OF SAFETY**

  DPH is pursuing new policies and procedures to emphasize and strengthen its culture of safety throughout the organization, to ensure employees understand their responsibilities, meet all safety obligations and promptly report possible abuse or safety concerns.

- **MEDICATION MANAGEMENT**

  Changes to LHH's medication management program will ensure it meets best practices, since medication administration is one of the most invasive and frequently used clinical interventions performed in the long-term care setting and susceptible to errors or abuse.

- **QUALITY MANAGEMENT**

  DPH will standardize its quality management processes, update reports and assessment tools, ensure employees understand their role within quality management, and improve reporting protocol, to ensure a high functioning and effective quality management program.

- **LEADERSHIP**

  LHH's new leadership and management team is fully engaged in and committed to the reform process, and to supporting staff in ensuring a culture of safety and overall employee accountability.

- **HUMAN RESOURCES**

  DPH is assessing human resources functions at LHH to ensure best practices in hiring processes, employee training, work assignments, administrative investigations, discipline, and appropriate authorization for any secondary employment, to ensure high employee engagement, satisfaction, and accountability.

LHH will:

- Demonstrate continuous compliance with all State and Federal regulations by successful implementation of the Plan of Correction associated with the most recent CMS 2567 (Statement of Deficiencies) and by demonstrating sustained compliance during future surveys
- Report monthly to the JCC and quarterly to the Board of Supervisors on compliance with regulations and standards
- Pursue the long-term goal of applying for Joint Commission (or other relevant body) accreditation

Status: The approved Plan of Correction is in progress, most items have been completed. (See Appendix 1: CDPH Findings and Plan of Correction, for status details.)

(2) Reorganization of hospital leadership and the quality and safety management program

There have been interim changes made to LHH leadership structure. Changes in structure, functions and personnel will continue.

DPH has worked in collaboration with law enforcement, the Public Conservators Office, state and federal licensing and certification bodies, families, decision makers, and patients to ensure patient safety at LHH. A Plan of Correction has been developed based on regulatory survey findings, accepted by relevant regulatory agencies and is in the process of being implemented.

A number of comprehensive changes have been implemented focused on the LHH Quality Management program, the recognition and reporting of abuse, and the responsibilities of staff as mandated reporters. Additionally, changes to the medication management process, the safety and security of access to affected units, increased staff supervision, and the screening and assessment of patients (specifically around change in condition, returning from out-on-pass, and the recognition of patient abuse) are being implemented.

LHH will:

- Appoint permanent CEO
- Implement policy and procedure revisions necessary for the Plan of Correction
- Reinforce comprehensive and ongoing education and training for staff regarding expectations of being a mandated reporter, as well as other key concepts from the Plan of Correction
- Provide competency-based education for the Charge Nurse role, Diversity and Inclusion and Cultural Competence for staff at LHH
- Develop and implement processes that actively promote collaboration and engagement between the Quality Management Department, unit leadership and front-line staff
- Develop and implement training programs for Quality Management staff to ensure best practices within the department
- Create standard processes for Quality Management workflows (e.g., investigations, event management, the RCA process and reporting to CDPH)
- Reorganize the Quality Management Department, operations structure and reporting
- Appoint permanent Quality Management Director
- Analyze culture of safety questions from staff engagement survey (administered March 2019) and partner with front-line staff in each unit to develop tangible improvements
- Repeat the Culture of Safety survey every 18-24 months

Status: These steps are in progress, some have been completed. (See Appendix 1: CDPH Findings and Plan of Correction, for status details.)

(3) Preparing LHH to better serve its patients in the future

Although it is a critical step in doing so, there is more to reform LHH than just coming into compliance with regulatory findings. The goal for LHH is to build a best-in-class long-term care facility worthy of the patients and the people of San Francisco. This will require dedication, collaboration and focus.

LHH will:

- Develop a request for proposal (RFP) to partner with long term care consultants to align the care of LHH patients with the industry best practices and also partner with local and national long-term care and geriatric care experts to assist with planning and the development of the RFP described above
- Review and implement recommendations from consultant(s) and other key stakeholders that support ongoing improvement, and best-practices in the use of metrics and reporting to ensure appropriate oversight

Status: The RFP is not yet in development. (See Appendix 1: CDPH Findings and Plan of Correction, for status details.)

CONCLUSION

The leadership of LHH and DPH have made a firm commitment and taken significant steps to improve patient care. The Plan of Correction has been approved by the relevant regulatory agencies and LHH is on the path to ensure ongoing regulatory compliance.

LHH will go further than meeting regulatory standards, however. This plan is designed to go beyond the reactive aspects of the Plan of Correction submitted to CDPH and to focus on the proactive steps necessary to change the organizational culture at LHH. Patient safety remains a top priority of LHH, with a commitment to preventing future safety issues, and ensuring that any such issues are immediately identified and addressed.

This plan outlines steps with respect to hospital leadership, the LHH quality and safety program and human resources, as well as a long-term path to reestablishing LHH as the world-class facility San Franciscans deserve.

LHH will report regularly to the Mayor, the Board of Supervisors and the Health Commission on its progress.

APPENDIX 1: CDPH Findings and Plan of Correction

2657 SECTION(s)	FINDING(s)	CORRECTIVE ACTIONS	STATUS
483.10	Failed to protect the privacy and confidentiality of 19 residents when photographs and videos were taken and shared by two staff members	• Wellness checks for the 19 residents identified. • Employees who participated in identified misconduct no longer employed by the City and County of San Francisco. Nursing certification and licensing boards informed. • Nurse Managers for all Neighborhoods conducted interviews and evaluations. • Training for all staff regarding the appropriate use of cell phones • Training provided to managers, supervisors and directors on use of electronic devices. • Flyers and signage for residents and visitors place regarding the use of cell phones, prohibiting photography without consent.	Completed May-August 2019 [highlighted]
483.10	Failed to ensure that five residents were free from chemical restraints	• Wellness checks for the 5 residents identified. • Employees who participated in identified misconduct are no longer employed by the City and County of San Francisco. Nursing certification boards informed. • Nurse Managers for all Neighborhoods conducted interviews and evaluations regarding breach, abuse or neglect. • A door monitor was implemented on North 1 requiring all visitors and staff to sign in. • The Nursing Department implemented a random audit including medication administration, narcotic waste, cycle count, and medication administration documentation for all 13 neighborhoods across all 3 shifts. • Multidisciplinary diversion prevention committee convened to address concerns, develop policy, review data, and provide a process for diversion detection and review events or circumstances where there is suspicion of diversion. • A standardized protocol was created for evaluating residents with altered mental status (AMS), somnolence or change in condition (including respiratory depression), which includes comprehensive urine toxicology test to identify the presence of non-prescribed medications. • Revised hospital standards regarding wasting controlled substance to mitigate diversion of narcotic medications. Communicated to staff. • Implemented a screening process for residents when returning from "out on pass" to prevent bringing illicit substance(s) or non-prescribed medication(s) to the facility. • Pharmacy implemented a short cycle dispensing model to limit availability of medications to 48-hour supply in the medication carts beginning April 2019 on a pilot unit and hospital-wide on July 8, 2019. • Bar code medication administration will be implemented hospital wide at LHH as part of the EPIC electronic health record (EHR) implementation. • LHH Physicians simplifying medication administration to reduce polypharmacy risks for residents, eliminating all "partial doses" to reduce error rate in administration and opportunity for diversion. • Training all staff regarding Physical and Chemical Restraints as forms of abuse; actions to take should they see, hear or suspect abuse and their role as mandated reporters.	Completed May-August 2019 [highlighted] Others in progress/ongoing

483.12	Failed to protect seven residents from verbal, physical and mental abuse	• All appropriate actions taken for 7 residents identified to ensure wellness.
		• Employees who participated in identified misconduct are no longer employed by the City and County of San Francisco. Nursing certification boards informed.
		• LHH reported all incidents to:
		  ○ California Department of Public Health, Licensing and Certification Branch
		  ○ Ombudsmen
		  ○ Local Law enforcement (San Francisco Sherriff Department, San Francisco Police Department)
		  ○ Patients, or decision maker if conserved
			Completed May-August 2019 [highlighted]
			
			Others in progress/ongoing

		• Nurse Managers for all Neighborhoods conducted interviews and evaluations regarding breach, abuse or neglect. • All Laguna Honda employees completed two in-service trainings: role as mandated reporters and timely reporting; education regarding identification of abuse, both physical and chemical restraints, abuse prevention, privacy and confidentiality, and resident monitoring and support. • Nurse Managers for all Neighborhoods initiated a standardized tool and process to conduct employee supervision and check-in with all nursing staff members. • A monthly review to track facility compliance and timely reporting will continue.	

483.12	Failed to develop and implement abuse prevention policy and procedure when:
	1. The facility did not identify incidents of abuse
	2. The facility failed to report incidents of abuse in a timely manner to CDPH and the residents or their responsible person
	3. The facility failed to train staff as mandated reporters
		• All appropriate actions taken for residents identified to ensure wellness.
		• Employees who participated in identified misconduct are no longer employed by the City and County of San Francisco. Nursing certification boards informed.
		• Nurse Managers for all Neighborhoods have conducted interviews and evaluations regarding breach, abuse or neglect.
		• Educating, reinforcing and sustaining staff knowledge and awareness of their role as mandated reporters at LHH:
		  o "Badge Buddies" (physical cards that hang behind the ID badges that each staff member is required to wear at all times) are being created with the reporting requirements to State Agencies, Ombudsmen, Law enforcement and Nursing Operations to provide a quick reference. These badge buddies will include the relevant telephone numbers.
		  o In-service training with accompanying post-tests.
		  o Posters with reporting guidelines and contact information for State Agencies, Ombudsmen and Law Enforcement and Nursing Operations.
		  o A written communication from the Chief Executive Officer.
		  o Case Presentations for staff on all shifts in each neighborhood.
		• Communication and training have been undertaken with all staff regarding Physical and Chemical Restraints as forms of abuse; actions to take should they see, hear or suspect abuse and their role as mandated reporters.
		• Reorganization of the Quality Management Department to create standard work regarding the investigation, assessment and reporting of adverse events, abuse, and other unusual occurrences to state and federal agencies.
		• Results of employee engagement survey disseminated. Action plans will be formulated to address opportunities regarding LHH Culture of Safety.
		• A monthly review of reported incidents to track facility compliance and timely reporting completed by Quality Management Nurses.
			Completed May-August 2019 [highlighted]
			
			Others in progress/ongoing

483.25	Failed to ensure the safety of four residents by not monitoring/supervising effectively	• All appropriate actions were taken for four residents identified to ensure wellness. • Charge nurses will use the standardized protocol for evaluating residents with altered mental status (AMS), somnolence or change in condition (including respiratory depression) on their neighborhoods, as described in corrective actions for TAG 605. • A monthly review of reported incidents to track facility compliance and timely reporting completed by Quality Management Nurses. • Observations of clinical practice using the lift equipment will be incorporated into "Employee Supervision" process. • New protocol to be implemented for screening residents when returning from a pass to prevent the bringing of illicit substance(s) or non-prescribed medication(s) to the facility. • New protocol regarding appropriate supervision of resident visiting one-another from different neighborhoods. • Nursing Staff will complete in-service training on procedure for screening residents upon return from a pass and when to initiate a clinical search.	Completed May-August 2019 [highlighted] Others in progress/ongoing